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ABSTRACT

This paper presents a review of the short- and long-term treatments for children who have been sexually abused. Short-term group therapy, long-term group therapy, short-term individual, and long-term individual therapy were each evaluated in terms of efficacy in alleviating symptoms associated with sexual abuse. The paper also evaluates the strengths and weaknesses of the studies. The review of the literature indicates that short-term group therapy was effective in reducing symptoms in children who have been sexually abused. Studies of long-term group therapy indicated conflicting evidence as to its efficacy in alleviating symptoms. Strong evidence was found to suggest that short-term individual cognitive therapy in addition to parallel parental treatment produced a decrease in symptoms in sexually abused children. Future research is need in the area of long-term treatment to determine which symptoms are amenable to long-term treatment, whether early intervention prevents or suppresses symptoms, and to further understand the benefits of short-term treatment and how it differs in its effect from long-term treatment. Further studies of asymptomatic children may shed light on questions of the sleeper effects, resiliency in children, and differences in the type of abuse on children's symptom profiles. (Contains 94 references.) (Author/JDM)

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THE EFFICACY OF SHORT- AND LONG-TERM THERAPY IN THE TREATMENT OF CHILDHOOD SEXUAL ABUSE: A REVIEW OF THE LITERATURE

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

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of the Requirements for the Degree

Doctor of Psychology

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A REVIEW OF THE LITERATURE

by

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THE EFFICACY OF SHORT- AND LONG-TERM THERAPY IN THE TREATMENT OF CHILDHOOD SEXUAL ABUSE: A REVIEW OF THE LITERATURE

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Stacey Y. Aoto-Sullivan

A review of short and long-term treatments for children who have been sexually abused was conducted. Short-term group therapy, long-term group therapy, short-term individual, and long-term individual therapy were each evaluated in terms of efficacy in alleviating symptoms associated with sexual abuse. The strengths and weaknesses of the studies were aiso evaluated. The review of the literature indicated that short-term group therapy was effective in reducing symptoms in children who have been sexually abused. Studies of long-term group therapy, however, indicated conflicting evidence as to its efficacy in alleviating symptoms. Strong evidence was found to suggest that short-term individual cognitive therapy in addition to parallel parental treatment produced a decrease in symptoms in sexually abused children. Research in the area of long-term individual treatment was sparse, and studies that were done were poorly designed. Recommendations for future research are also included in this review.

TABLE OF CONTENTS

PAGE

ACKNOWLEDGEMENTS v

DOCTORAL RESEARCH PAPER

Introduction 1

Past Studies of Childhood Sexual Abuse 2

Models 3

Variables 4

Assessment and Treatment 5

Treatments for Sexually Abused Children 7

Short-term Group Treatment 9

Long-term Group Treatment 13

Individual Short-term Treatment 16

Evolution of treatment 17

Controlled studies 17

Quasi-experimental studies 23

Individual Long-term Treatment 30

Conclusions 32

REFERENCES 35

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THE EFFICACY OF SHORT AND LONG-TERM THERAPY IN THE TREATMENT OF CHILDHOOD SEXUAL ABUSE: A REVIEW OF THE LITERATURE

Introduction

An increased awareness of the prevalence of childhood sexual abuse and the changing environment of health care have fueled researchers and clinicians to investigate treatment focused on ameliorating the immediate and long-term sequelae of childhood sexual abuse. Finkelhor (1994) reported that approximately 150,000 confirmed cases of child sexual abuse were reported to child welfare authorities in the United States during 1993. Prevalence estimates indicated that in America 20% of women and 5% to 10% of men have experienced some form of sexual abuse before the age of 18 (Finkelhor, 1994). These numbers are thought to be low due to underreporting, especially in regard to reported incidents of sexual abuse among males.

Research to date has extensively documented the impact of sexual abuse on children. Beitchman, Zucher, Hood, DaCosta, and Akman (1991), in their review of short-term effects of child sexual abuse, reported that most children and adolescents have suffered a variety of psychological consequences as a result of sexual abuse, and that this is characteristic of clinical samples in the general population. Conte and Berliner (1988) indicated that symptoms of abuse among children who have been sexually abused range

from asymptomatic to severe. Immediate effects of child sexual abuse include depression, anxiety, suicidal ideation, low self-esteem, delinquency, academic problems, and sexualized behavior (Becker, Alpert, BigFoot, Bonner, Geddie, Henggeler, Kaufman, & Walker, 1995). Stevenson (1999) reviewed the literature on the long-term sequelae of child sexual abuse and reported a number of psychological and behavioral problems in childhood, including age inappropriate sexual behavior, sexual behavior problems, fearfulness, anxiety, post-traumatic stress disorder, dissociative reactions, self-destructive behavior, suicide, antisocial behavior, low self-esteem, and depression. Studies have also found that the psychological and behavioral correlates of sexual abuse continue into adulthood. These include sexual dysfunction, anxiety, post-traumatic stress disorder, low self-esteem, depression and suicidal behavior, substance use, borderline personality disorder, somatization disorder, revictimization, and sexual abuse perpetration (Stevenson, 1999). These severe long-term consequences highlight the need to find the following: (a) well designed studies defining the specific disorder and its etiology and (b) empirically validated treatments that address sexual abuse and its long-term psychological and behavioral impacts on individuals.

Past Studies of Childhood Sexual Abuse

The variability in symptomotology displayed by children who have experienced sexual abuse and the lack of a consistent set of sequelae have created a problem in establishing a valid definition of the syndrome. Without a concise definition, it is difficult to understand the mechanism of the syndrome, and without a descriptive model for the syndrome, it is difficult to identify the pathogenesis and develop an appropriate treatment.

Models

Some exploratory studies have found that many of the symptoms experienced by abused children have met criteria for Post Traumatic Stress Disorder (PTSD) (McLeer, Deblinger, Atkins, Foa, & Raphe, 1988; Kendall-Tackett, Williams, & Finkelhor, 1993). Thus, one of the first models which has attempted to explain the syndrome of childhood sexual abuse was a PTSD model. Sexual abuse was seen as an uncontrolled disaster or stressor inflicted on an unwilling child that caused the child to become vulnerable to PTSD type symptoms (Benedek, 1985). Finkelhor (1987), a leading researcher in the field of child abuse, disagreed with the Post Traumatic Stress Disorder (PTSD) model and stated that many theoretical problems have arisen in its use. Furthermore, he stated that the model is inadequate to explain other symptoms that have been well documented in the literature, such as self-blame and sexual problems. He explained that the field is in need of a more comprehensive and multifaceted model of traumatization that includes subtle nuances specific to child sexual abuse. He proposed an alternative model called the "Four Traumagenic Dynamics of Sexual Abuse." The four traumagenic dynamics are as follows: (a) traumatic sexualization, (b) betrayal, (c) stigmatization, and (d) powerlessness (Finkelhor, 1987). His effort was one of the early attempts to better describe the affects of sexual abuse on children.

Other researchers agreed with Finkelhor and were strongly influenced by the idea of a multifaceted model of traumatization to account for the variation in symptoms which children of sexual abuse display. Briere (1992) also developed a multifaceted model of sexual abuse which included the following: (a) negative self-evaluation, (b) chronic perception of danger or injustice, (c) powerlessness and preoccupation with control, (d)

dissociative control over awareness, (e) impaired self-reference, and (f) reduction of painful internal states. Pilkonis (1993), in a different vein, introduced a model of attachment and stated that symptoms experienced by sexually abused children result from the experience of trauma in relation to the development of attachment. System theorists posit a model in which family dysfunction or a general maltreating environment, rather than the sexually abusive activities per se, is understood to be the root of the trauma in most sexually abused children (Kendall-Tackett et al., 1993).

Variables

Some of the difficulty in understanding and responding to children's experience of sexual abuse has been the wide range of behaviors and variables associated with the problem. For example, offenders have ranged from family members and friends to strangers. Acts of sexual abuse have also varied in nature, frequency, intensity, and duration. Additionally, victims have been children of different ages at different stages of cognitive, physical, and emotional development. All these variables make the problem more complex. Also, symptoms vary in relation to the sex of the child, the nature of the duration of abuse, age, number of perpetrators, amount of time since abuse, and the relationship between the child and the perpetrator (Becker, Alpert, BigFoot, Bonner, Geddie, Henggeler, Kaufman, &Walker, 1995). A growing number of studies have indicated that the developmental outcome of sexually abused children may also be influenced by sociocultural factors and family climate such as socioeconomic status, maternal interaction with the child, child health problems, and the absence of a male head of the household (Becker et al., 1995).

Assessment and Treatment

The complexities associated with the experience of childhood sexual abuse have created difficulty for practitioners attempting to devise adequate assessment and treatment to address abuse specific behavior or sequelae. As stated before, devising an explicit theoretical construct to be correlated with recognized therapeutic interventions, or to provide the basis for their development, has been the field's greatest challenge (Berliner & Wheeler, 1987). Researchers continue to develop standardized assessment and treatment to address the problem of child sexual abuse, but progress has been labored due to ethical concerns regarding participants' rights. Through the efforts of researchers and clinicians, the past decade of research has revealed new directions as well as important findings for clinical treatment of this population.

In their review of the research on the treatment of sexually abused children, Finkelhor and Berliner (1995) reported that the studies have documented improvements in sexually abused children consistent with the belief that therapy facilitates recovery. Only five of the studies, however, provided evidence that the recovery was not simply due to the passage of time or some factor outside therapy. Furthermore, the studies they reviewed suggested that externalizing behaviors, such as aggressiveness and sexualized behavior, were particularly resistant to change and that some children do not improve. They critiqued the research and stated that further long-term follow-up studies need to be done to investigate the optimal duration of treatment (Finkelhor & Berliner, 1995). Finkelhor and Berliner (1995) noted that virtually none of the treatment evaluation studies had examined the problem of treatment dropouts. Evaluating the problem of attrition is important in understanding the variables associated with treatment

compliance. Attention to such variables would make conclusions of any study more relevant and generalizable.

Finkelhor and Berliner (1995) also noted the lack of abuse-specific measures available to further define the symptomotology. They suggest that if researchers are to test the basic assumption that there are abuse-specific effects that can be remedied by treatment, then studies need to use abuse-specific measures in addition to generic ones like the Child Behavior Checklist (CBCL). The most recently developed abuse-specific measures include the following: the Trauma Symptom Checklist for Children (Briere, in press), the Children's Impact of Traumatic Effects Scale (Wolfe, Gentile, & Wolf, 1989), the Children's Attributions and Perceptions Scale (Mannarino, Cohen, & Berman, 1994), the Negative Appraisals of Sexual Abuse Scale (Spaccarelli, in press), and the Child Sexual Behavior Inventory (Friedrich, Grambasch, & Damon, 1992).

Finkelhor and Berliner (1995) further commented on the inadequacy of comparing group means to provide detailed information about the effects of treatment or to describe the characteristics unique to sexually abused children. Group means might provide a gross measure of change in a given group but contribute little information on the variability of individual responses to treatment. This comparison also pays little attention to the fact that some subjects improve, some deteriorate, and some do not change (Finkelhor & Berliner, 1995). They suggest that individual analyses of scores, especially for those who drop-out, are important in providing information as to the specific characteristics of those whom improve, deteriorate, drop-out, or do not change.

Kendall-Tackett et al. (1993) with Finkelhor and Berliner (1995) also agreed that little research has been done to address the situation of sexually abused children who

appear to be asymptomatic. Asymptomatic children are important to investigate because they may represent the percentage of the population in which symptoms may be muted or masked. Such an occurrence could be due to several factors, such as poor measures, "sleeper effects," resilient children, or perhaps a difference in the type of abuse.

Surprisingly, the effects of long-term treatment have not been a focus of much research. Yet, Lanktree and Briere's (1995) study of the "Outcome of Therapy for Sexually Abused Children: A Repeated Measures Study" found that those children who continued in treatment evidenced a continued pattern of decrease in symptomatology. This conclusion, however, has limited generalizability due to the absence of a comparison group. A comparison group design could demonstrate that change might be due to the treatment itself rather than simply the passage of time. Nevertheless, Lanktree and Briere's (1995) findings have provided valuable hypotheses for future investigation.

This paper will review the efficacy of both short-term/brief and long-term treatments in addressing the symptoms of children who have been sexually abused. Key studies in the past decade will be reviewed with an emphasis on the past five years of research that followed the 1995 review by Finkelhor and Berliner.

Treatments for Sexually Abused Children

Several treatments have been proposed over the past decade with varying modalities and lengths. The most common treatments reported in the literature were short-term individual and short-term group with long-term individual and long-term group being less frequent. Each will be discussed and evaluated in this paper. Chambless and Hollon's (1998) recently proposed schema for evaluating or defining empirically

supported therapies (EST) will be used to provide a criterion of measure for efficacy of treatments reviewed in this paper. The criteria are outlined below.

1. Comparison with a no-treatment control group, alternative treatment group, or placebo (a) in a randomized control trial, controlled single case experiment, or equivalent time-samples design and (b) in which the EST is statistically and significantly superior to no treatment, placebo, or alternative treatments or in which the EST is equivalent to a treatment already established in efficacy, and power is sufficient to detect moderate differences.

2. These studies must have been conducted with (a) a treatment manual or its logical equivalent; (b) a population, treated for specified problems, for whom inclusion criteria have been delineated in a reliable, valid manner; (c) reliable and valid outcome assessment measures, at minimum tapping the problems targeted for change; and (d) appropriate data analysis.

3. For a designation of *efficacious*, the superiority of the EST must have been shown in at least two independent research settings (sample size of 3 or more at each site in the case of single case experiments). If there is conflicting evidence, the preponderance of the well-controlled data must support the EST's efficacy.

4. For a designation of *possibly efficacious*, one study (sample size of 3 or more in the case of single case experiments) suffices in the absence of conflicting evidence.

5. For a designation of *efficacious and specific*, the EST must have been shown to be statistically significantly superior to pill or psychological placebo or to an alternative bona fide treatment in at least two independent research settings. If there is conflicting

evidence, the preponderance of the well-controlled data must support the EST's efficacy and specificity.

Short-term Group Treatment

Perhaps the most cost effective of all treatments for children in the literature has been short-term group treatment. Group treatments have been advocated in the literature and in the field to address issues of isolation, stigmatization, and difficulty establishing trust that children of abuse commonly experience.

Six studies were reviewed, and four of these studies reported a significant decrease in certain symptoms associated with child sexual abuse. Two of the studies reported inconsistent findings with no significant differences between control group and treatment group.

Hiebert-Murphy, DeLuca, and Runtz' (1992) study consisted of five girls ages seven to ten. The length of treatment was nine weeks. Their study produced inconsistent findings. Several weaknesses in their design should be noted, which may have contributed to the inconsistent findings. One observation made was that such inconsistent findings might be due to the young age of the sample (7 to 9). Prior research has suggested that younger children often have difficulty understanding measures that include negatively worded items (Marsh, 1986). Hiebert-Murphy et al. (1992) pointed out that the anxiety and self-esteem measures administered in their study contained negatively worded items. Such wording might have impeded accurate measurements due to the developmental limitations of this age group. Furthermore, the time in treatment for these participants was three weeks shorter than most of the other studies reviewed in this

article. It may be that given a few more weeks in treatment the results would have indicated more consistent findings.

Grayston and DeLuca (1995) also reported no significant results between control group and treatment group. They examined 12 boys, ages seven to ten. The major weakness in their study, which may have significantly impacted their findings, was that all participants in the study did not attend all sessions. Attrition is an important aspect to address in a study. If clients do not receive the treatment as was intended, it is difficult to assess its effect. Small sample size may also account for the pattern of results in this particular study. The subjects were not randomly assigned, and the potential of nonequivalent groups may have impacted the results. Delayed treatment effects may also be a factor which longer follow-up studies would have been able to address. Several children were also involved in other forms of therapy and may have made treatment gains prior to commencement of treatment or during treatment, confounding the results of the study. Problems with self-report measures have also been an issue, along with family support, which was not controlled in this study. Some children were in more chaotic, less supportive home environments with custody and access disputes between parents, which might have been distressing to the child. Family support has been observed as one of the mediating factors of abuse symptoms reported in past research. As such, it is important to control for family support to study its impact on symptoms of abuse.

The majority of the short-term group studies, however, reported significant reductions in symptoms associated with child sexual abuse. Hack, Osachuk, and DeLuca (1994) studied six boys between the ages of 8 and 11 years old. They noted in their study a significant reduction in depression but found only modest support for reduction in

behavioral problems as reported by the boys' parents/guardians. The study by Hack et al. (1994) also suffered from a low number of participants, which makes it difficult to generalize reported treatment gains. In subject by subject analysis of the data, however, Hack et al. (1994) found a clinically significant decrease in anxiety, depression, internalizing and externalizing problems and increased self-esteem. Noteworthy was that all treatment gains were maintained at the seven-month follow-up.

McGain and McKinzey's (1995) study also showed significant symptom improvement with group treatment. Understanding the problem of a lack of controlled studies in the literature, McGain and McKinzey launched a matched control group treatment design of 30 female participants, 9-12 years old. The matched control group consisted of those who were on a waiting list and could not start treatment right away. The program's goals for the group were as follows:

> a) to provide a safe environment where the children can freely discuss their abuse; b) to increase the children's self-worth; c) to prevent any remolestation; d) to avoid any long-range psychological problems; e) to provide appropriate and nonexploitive male and female adult role models; f) to provide support for the child victim when court proceedings must be attended; g) to educate the child about practical steps they can take to protect themselves; h) to facilitate communication by the victim about the dynamics of abuse; i) to create a peer support system for the child that may be viable over time; and j) to obtain support and approval for treatment of the child's family. (McGain & McKinzey, 1995, p. 1162)

The authors cite Kitchur and Bell's (1989) group treatment as their model. This model was a combination of different elements from several group treatment models in the field, such as cognitive behavioral, skills training, and educational therapies. They reported significant reductions in behavioral problems. Specifically, the results of the study done by McGain and McKinzey (1995) showed decreases in the areas of conduct disorder, socialized aggression, attention problems, immaturity, anxiety-withdrawal, motor excess, problem intensity, and specific kinds of problematic behavior.

Major findings by Sinclair, Larzelere, Paine, and Jones (1995) showed that participants and their caregivers noted significant decreases in internalizing behaviors and PTSD symptoms, but conflicting evidence was found in relation to externalizing problems. Participants were sexually abused adolescent females, ages 12-18, living in a group home setting. Girls who participated in the 20-week group reported a significant decline in externalizing problem behavior while their caregivers noted only an insignificant decrease. Unfortunately, this study is less robust than McGain and McKinzey's (1995) study due to the lack of a control group. Also, the caregivers' awareness of the purpose of the study may have biased the results. The strength of the study lies in the use of multiple standardized measures to assess different aspects of sexual abuse symptoms. By using multiple measures, they were able to obtain a more accurate picture of the severity and the impact of the sexual abuse on the participants.

Nelki and Watters (1989), unlike Sinclair et al. (1995), did not provide good standardized instruments for assessment. For their study with females ages 4 to 8 years old, they used a non-standardized questionnaire and, therefore, the validity of their results is questionable at best. The most significant weaknesses in their research were lack of

control groups and long-term follow-up with larger and more diverse groups of participants. Eliminating these weaknesses in this study would have contributed both more robust data and greater generalizability of the findings.

Long-term Group Treatment

Long-term group treatment studies were not as effective as short-term/brief group treatments in demonstrating that treatment reduces symptomology associated with childhood sexual abuse. Rather, long-term group treatment studies reflected conflicting evidence. Downing, Jenkins, and Fischer (1988) did a long-term group treatment study. They found that with 22 children ages 6 to 12, the psychodynamic treatment group and the reinforcement treatment group improved clinically. Both treatments resulted in the remediation of sleep problems and decreased sex play with others. Neither, however, was effective in reducing sexual self-stimulation, and to a lesser degree, enuresis also seemed resistant to either treatment. These findings suggest that sexual preoccupation and/or certain sexualized behavior may be more resistant to change in treatment. Comparison of the two treatment groups revealed no significant differences. Although the study demonstrated no significant differences between groups, it does seem to suggest that reinforcement treatment effected improvement at a faster rate than psychodynamic treatment.

Although Downing et al. (1988) utilized multiple informants to collect data, which was a strength, several weaknesses in the study call into question the validity of the findings. The more serious limitations were the lack of standardized measures to assess symptoms and the fact that the teachers/raters in the study may have been

contaminated by experimenter bias. They were able to ascertain the different approaches of the two groups based on the recommendations of the counselors.

Hyde, Bentovim, and Monck (1995) conducted a long-term treatment study with 47 children, ages 13 and 14, and their mothers/caregivers. Treatment consisted of two groups: (a) a psychoeducationally based treatment group, with dynamic elements, in addition to family network meetings; and (b) psychoeducationally based family network meetings. Treatment lasted for 12 months. Analysis of the whole treated population revealed significant improvements in self-reported depression scores and in mothers'/ caregivers' reports of the children's health and behavior. No significant changes were observed in the other three measures (children's self-esteem, reports of their own health and behavior, and teacher's reports of the children's behavior). Furthermore, the results suggested no significant differences in the amount of improvement on any of the research measures between those children attending family network meetings alone and those attending family/network meetings with the addition of group.

In contrast, clinician's ratings of family treatment aims in the group showed significant benefit from the addition of group work. Significant improvement was observed in ratings on the following family treatment aims:

1. The child's ability to share painful feelings
2. The child's ability to speak without being scapegoated in the family
3. The child's ability to see positive features in him/herself, and the ability of the original family (and current caregivers where the child lived with a new family) to see positive features in the child.

4. The family's ability to recognize the child's age-appropriate needs and the damaging effects resulting from the abuse.

Such contradicting evidence between clinician's ratings must be understood within the frame of limitations that the study presented. Although Hyde et al. (1995) attempted to provide an alternative treatment for comparison of any changes between the treatment groups, weaknesses pervade the study. Not unlike previous research studies examined, Hyde, Bentovim, and Monck's (1995) suffered from a small number of subjects. Also, the sample was diverse in age, which contributed to a variety of measures being used that could not be compared for all subjects in the treatment group. Since both treatments were psychoeducationally based, it is also questionable whether the two treatments were different enough to demonstrate change between the two groups. Self-report measures were also used, which tend to be more vulnerable to error due to distortions in self-perceptions. Clinical assessments, however, may be more sensitive to change and do show a trend toward a reduction in symptoms; although one must keep in mind the component of experimenter bias in this case.

Other studies, such as Hall-Marley and Damon (1993), also suffered from a small number of participants with no control group. The design of their study was a single treatment group with pretest-posttest measures. Their study involved 13 children between the ages of 4 and 7 years old, who participated in parallel group treatment with their non-offending caretaker for 12 to 18 months. Hall-Marley and Damon (1993) tried to expand their investigation by including a sexual abuse specific measure, Child Sexual Behavior Inventory (CSBI), but all measures were based on self-reports. They, too, found a significant decrease in the Child Behavior Checklist (CBCL) scores for subjects taken

together as a whole (that is, boys and girls collapsed). Hall-Marley and Damon (1993) also documented a statistically significant decrease in CSBI scores for girls as a group. The boys' data could not be analyzed due to the absence of scores for four subjects. This limitation significantly biases the results of the CSBI scores for the boys' data, and the conclusions that can be drawn from the data as a whole are therefore limited in their generalizability.

Furniss, Bingley-Miller, and Elburg (1988) focused on goal-oriented group treatment. Their approach was eclectic in nature and was not defined well in the literature. Some sessions were structured, and some were open-ended. They incorporated family sessions in addition to group work. Participation lasted anywhere from 7 months to 2 years. Furniss et al. (1988) reported that all participants were less anxious, had less sexualized behavior, had increased trust in relationships, had increased self-esteem, and experienced an increase in self-assertion. Similar to Nelki and Watters (1989), however, no controls or formal measures were used; as a result, it is difficult to isolate specific contributions of the group work in contrast to the family work or other interventions in the overall treatment approach.

Individual Short-term Treatment

Under the category of individual short-term and brief treatment, a new category has emerged in recent years. This new subcategory is called parallel treatment. This is treatment where the child is in his or her own individual therapy and the non-offending caregiver is in therapy simultaneously with a separate therapist of his or her own. Some therapists may categorize parallel treatment as a type of family intervention as well. This

type of treatment has yielded important findings in the current research, which will be discussed further in this paper.

Evolution of treatment. In the past, individual treatment for sexually abused children was seen as the treatment of choice due to the severity of symptoms experienced after the trauma. Group and family therapy were recommended after the child had become more stabilized. Now, however, research is demonstrating a trend toward family interventions or parallel treatment, at least with the non-offending caretaker, due to findings that suggested family support to be a remediating factor for abuse symptoms. Prior research found that children who had maternal support recovered more quickly (Kendall-Tackett, Meyer Williams, & Finkelhor, 1993). Maternal support was demonstrated (evidenced or shown) through believing the child and acting in a protective way toward the child (Kendall-Tackett et al. 1993). They also observed that the least symptomatic children (five years after disclosure) were those whose mothers were most supportive and whose families had less strain, enmeshment, and expressions of anger. Individual treatment in the past few years has also been required to be more accountable for efficacy of treatment due to managed care. However, even with the growing demands and pressures in the mental health environment today, few controlled designs have been done in the area of child abuse treatment.

Controlled studies. Out of the nine short-term or brief treatments evaluated in this study, only three were controlled designs (Celano, Hazzard, Webb, & McCall, 1996, Cohen & Mannarino, 1996, Debliner, Lippman, & Steer, 1996). All three of these controlled studies were randomized treatments with alternate comparison treatment groups. The other seven studies were quasi-experimental studies (Deblinger, McLeer, &

Henry, 1990; Wagner, Kilcrease-Fleming, Fowler, & Kazelskis, 1993; Lanktree & Briere, 1995; Miller & Boe, 1990), most with a pretest-posttest design with subjects serving as their own controls. The limitations of such studies were the lack of a comparison or control group to serve as a basis for determining change resulting from treatment. Without a comparison or control group, it is difficult to determine whether change has been caused by maturation, spontaneous remission, practice effects of testing, history, and/or other factors. All of the studies, with the exception of Downing, Jenkins, and Fisher (1998), used either formal standardized measures in their assessment or a standardized treatment approach. Five of the studies (Cohen & Mannarino, 1996; Deblinger, Lippman, & Steer, 1996; Kolko, 1986; Farrell, Hains, & Davies, 1998; Fenton, 1993) evaluated in this review had formal follow-up as recommended by Chambless and Hollon (1998) to meet one of the criteria for "Empirically Supported Treatments".

Overall, the controlled studies reported a reduction in abuse-related symptoms after treatment. Of these three controlled studies, only one reported that treatment yielded a significant decrease in symptoms over time (Celano, Hazzard, Webb, & McCall, 1996). Celano et al. (1996) also found that the alternative treatment in their study (supportive, unstructured psychotherapy that sexually abused girls and their mothers would ordinarily receive at their clinic) also yielded a significant decrease in symptoms over time. Their study is particularly significant for its attempt to incorporate in its measures those dynamics intrinsic to sexual abuse, that is, traumagenic beliefs. The four traumagenic dynamics which Celano et al. (1996) utilize in their study are based on Finkelhor and Browne's (1985) theoretical model of sexual abuse. The dynamics are as follows: a) self-

blame/stigmatization, b) betrayal, c) traumatic sexualization, and d) powerlessness (Finkelhor & Browne, 1985). They used the Children's Impact of Traumatic Events Scales-Revised (CITES-R) to measure these dynamics as well as PTSD symptoms. This was a departure from Deblinger et al.'s (1990) study, which limited its focus to PTSD symptoms or anxiety-related issues.

One limitation of Celano et al.'s (1996) study, was the lack of a no-treatment control group. They did attempt to estimate the effects of time on symptom improvement by examining the relationship between the time since disclosure and the child's symptomatology at pretesting. Analysis revealed no significant correlations between time and all dependent measures, suggesting that time alone is unlikely to account for the significant differences found in their sample. Another limitation of the study was the researchers' use of multiple statistical tests with a small sample. Such procedures make it more likely that researchers will commit a Type I error in which the null hypothesis is rejected, when it would be, in fact, true that treatment reduces abuse symptoms.

Celano et al.'s (1996) results further indicated a decrease in some traumagenic beliefs and in PTSD symptoms, whereas betrayal-related beliefs in addition to sex-related beliefs remained unchanged. Such findings were consistent with Lanktree and Briere's (1995) study with boys and girls ages 8-15 years old. Lanktree and Briere's (1995) study was a repeated measures study taken at 3 month intervals, which reported that sexual concerns did not decrease over six months of treatment. Also consistent with Lanktree and Briere's (1995) findings was that other problems, such as anxiety and depression, did decrease with short-term structured treatment.

Finkelhor and Berliner (1995) reported inconsistent findings in the outcome investigations they reviewed, which employed experimental designs that compared alternative treatments. In fact, Finkelhor and Berliner state that only one investigation, done by Cohen and Mannarinno (1996), demonstrated strong differences. Cohen and Mannarino's study affirmed advantages of abuse-focused cognitive behavioral therapy (CBT) versus nondirective supportive therapy (NST) in treating internalizing symptoms and sexualized behaviors. Cohen and Mannarino provided a fairly well designed study with a defined treatment manual.

Deblinger, Lippman, and Steer (1996) attempted to determine the efficacy of short-term cognitive behavioral treatment similar to that of Cohen and Mannarino (1996). Their results found that those individuals assigned to parent only and parent-child conditions reported significantly greater decreases in their children's externalizing behaviors than those children assigned to child only treatment. These results conform to those of Celano et al. (1996), which also suggested that cognitive behavioral and metaphoric treatment involving parents significantly decreased externalizing symptoms of abuse.

The significance of the study by Deblinger et al. (1996) lies in its demonstration of the efficacy of cognitive behavioral interventions in decreasing posttraumatic stress symptoms in sexually abused children. The study also added further support to the importance of involving parents in the treatment of the abused child. One shortcoming of this study was that the administration of the control condition (those individuals referred to an alternate community agency) resulted in many of the control subjects receiving varied and poorly defined interventions or no treatment at all. This called into question

the extent to which these findings were generalizable to other community based treatment programs, since the one in this study was poorly defined.

All three of the controlled studies, Deblinger et al. (1996), Celano et al. (1996), and Cohen & Mannarino (1996), worked with a defined treatment manual or an equivalent thereof, fulfilling Chambless and Hollon's (1998) second criterion for empirically supported psychological therapies. Cohen and Mannarino's study went one step further than Deblinger et al.'s (1996) study and provided a more defined alternative intervention, non-directive supportive therapy (NST), for the control subjects. This attributed greater power to the conclusions of their study regarding the index treatment. It should be noted, however, that six children in their study were removed from the NST group because of the persistence of serious sexually inappropriate behaviors. Cohen and Mannarino (1996) stated that had these children remained in the NST group, the NST CSBI post-treatment scores may have been higher, which would have affected outcomes.

Providing more evidence in favor of cognitive behavioral therapy (CBT), it is interesting to note that the same sexual behavior problems were evident in the CBT group, but no children from that condition were eliminated. No conclusions can be made at this point as to the meaning of such occurrences, but it would seem to have some clinical significance in favor of CBT treatment for this population.

Both Cohen and Mannarino (1996) and Deblinger et al. (1996) provided follow-up studies. Deblinger et al. (1996) currently has one of the longer follow-up studies underway (24 months) to assess the treatment's efficacy in producing more long-term change and to identify "sleeper effects." These are symptoms that do not manifest immediately after the abuse, but rather lie dormant until later in the survivor's life. In

theory, it is also possible that some of the delayed effects of sexual abuse are triggered by later developmental challenges that a survivor may face, effects which may not be accessible to therapy at an earlier time. These types of delayed effects would also be considered "sleeper effects." Such follow-up studies have been very important given the fact that many researchers and therapists who work with this population believe that the effects of sexual abuse persist into adulthood or may not emerge until later on in life at various intervals after disclosure. Also, in comparison to studies with adult survivors of abuse, long-term follow-up studies with children have been rather scarce.

Glasser (1991) suggested conservative estimates indicating that 3-6% of women experienced long-term psychological disturbance related to sexual abuse, with the rate in men likely half that number. Mannarino, Cohen, Smith, and Moore-Motily (1991) stated that retrospective studies of adult survivors of child sexual abuse consistently demonstrated that adults, mostly women, with a history of child sexual abuse were more prone to clinical depression, suicide attempts, drug and alcohol abuse, anxiety disorders, somatic complaints, and posttraumatic stress symptoms than were adults without such a history. The problem with retrospective studies, however, has been that data can be inaccurate due to poor recall of events or emotional and cognitive distortions of details. Mannarino et al. (1991) further commented on the problem of the veracity of data and stated that the difficulty was knowing whether or not the clinical problems noted were inevitable long-term sequelae of child sexual abuse. They noted that the difficulty is due to the fact that the majority of adults in these studies did not disclose the abuse as children and, thus, did not receive treatment for this specific issue as children. Therefore, they concluded, long-term follow-up studies of children are important in filling the

apparent gap in the literature as to the kinds of symptoms and vulnerabilities that might persist after the identification of child sexual abuse and its treatment.

Cohen and Mannarino's (1996) follow-up study revealed that the strongest predictor of positive outcome in their study at the 6 and 12-month follow-up was parental support. Such evidence again emphasizes the findings of previous studies that delineated the importance of including parents in treatment for sexually abused children. Conclusions also indicated that cognitive behavioral therapy was significantly more predictive of outcome than was the non-directive supportive therapy. This further supports the use of cognitive behavioral treatment for this population.

Quasi-experimental studies. Quasi-experimental designs were most popular in the research. Although these designs do not have the structure controls that make causal conclusions viable, such designs have contributed a great deal of knowledge to the field. Chambless and Hollon (1998) recommended that single case studies have a sample size of three or more at each site. Kolko's (1986) study, a single case design, falls short of this criterion with only one participant. However, it was a significant contribution to the literature in that it laid groundwork for the field at the time. Kolko (1986) reported that clinically significant improvement was obtained immediately following the introduction of cognitive behavioral treatment, at post-treatment, and at follow-up for all four target behaviors (voice quality, eye contact, physical gestures, and verbal content). Follow-up questionnaires (completed by the foster mother) also indicated significant improvement in social adjustment and relationship with peers. The foster mother reported at the one-year follow-up that the participant had not perpetrated or participated in any deviant physical touching or sexual molestation, for which he had initially been hospitalized.

Kolko (1986) used a multiple baseline design with multiple observations from other professionals working with the child, including the parents or foster parents. Other strengths included the use of blind raters randomly to evaluate role-play scenarios and an effort to control for observer expectation by using an individual blind to treatment condition to administer measures (O'Donohue & Elliot, 1992). An apparent limitation of this study relates to the collection of baseline data during a single session. O'Donohue and Elliott (1992) commented that data based on one observation may not be representative of actual pretreatment functioning and might be insufficient to establish a pattern of stable responding needed to make valid interpretations. Without assessing a stabilized pattern of pretreatment functioning, interpretations of the data are limited.

A study by Farrell, Hains, and Davies (1998) is one which extended previous research by utilizing a more defined sample of participants, four 8-10 year olds. Like Kolko (1986) these researchers used a multiple baseline design. They used frequent assessment points to gather information about the impact of treatment on the variables of sexual abuse symptoms. All four participants in this study reported a decrease in PTSD symptoms. Patterns of progress, however, differed considerably from child to child. Individual data analysis revealed that a decrease in anxiety was maintained at the three-month follow-up in all but one participant. Upon further investigation of the participant's history, the researchers found that she had been moved to another foster home prior to her follow-up visit. The researchers concluded that "Paige" may not have been able to transfer the skills gained in treatment to her new environment, and the transition to a new home might have created further stress and inconsistency for "Paige." This might have contributed to her increased anxiety scores. On the other hand, the one male participant

they called "Matt" did not report any anxiety or depressive symptoms throughout the study. He reported only PTSD symptoms, which decreased after the third session. Researchers concluded that high levels of reported social support and a stable family environment might have been a mediating factor in the decrease of symptoms for this participant.

The limitation of such single case designs, as the Farrel et al. (1988) and Kolko (1986) studies, is that they are highly specialized or tailored to the individual. This makes it difficult to replicate or generalize findings. Also, it was difficult to discern from Farrell et al.'s (1988) data whether the baseline was stable. With conflicting evidence, Chambless and Hollon's (1998) evaluation schema states that for a designation of efficacious, the superiority of the treatment not only needs to be observed in at least two independent research settings, but that the preponderance of the data must support the treatment efficacy. Due to the high degree of conflicting evidence in Farrel et al.'s (1988) study, the index treatment does not meet criteria for attribution of efficacy.

Another type of quasi-experimental design that has frequently been utilized in the literature has been pretest-posttest designs with no control group. Prior to her most recent study, Deblinger, et al. (1990) examined the effectiveness of a cognitive behavioral treatment program designed for sexually abused children suffering from posttraumatic stress disorder. Theirs was a pretest-posttest design with no control group. Repeated measures were utilized in which subjects served as their own controls. As in Deblinger et al.'s (1996) study, family intervention treatment was utilized in addition to the treatment of the child. Deblinger et al. (1990) concluded in their study that significant improvement of PTSD symptoms as well as improvement in the externalizing and internalizing

subscales of the CBCL had been achieved. The reliability of such findings, however, is uncertain due to their use of a non-standardized PTSD measure by which to compare results. Self-report measures of anxiety and depression were also difficult to interpret. Deblinger et al. (1990) reported in the study that nine children did not complete the Child Depression Inventory (CDI), and ten children did not complete the State-Trait Anxiety Inventory-Children's Version (STAIC), as they fell below the age required for completing these measures. The analysis of pretreatment and post-treatment scores revealed significantly decreased state and trait anxiety scores as well as significantly decreased depression, although the limited sample size and the problem of incomplete data should be kept in mind.

Data from this study revealed that the nature of the abuse had a tendency to influence a subject's treatment responsiveness. They found that those subjects who experienced less severe sexual abuse showed less improvement on the CBCL subscales. Such findings can be alternatively interpreted to reflect the tendency for subjects who have experienced less severe sexual abuse to be suffering fewer symptoms at baseline, and, as a result, to reflect less overall improvement. Another weakness in the design is the broad age range of participants; this range contributed to a less defined subject pool for the generalization of results. Deblinger et al. (1990) also used few assessment points to sufficiently assess change related to treatment.

An investigation by Wagner, et al. (1993), another quasi-experimental study, used clinicians who were double-blind to condition. They found that after six sessions of psychoeducationally based treatment for sexual abuse, clients/participants evidenced a significant decline in CDI scores and displayed significant improvement in self-concept.

Another hypothesis investigated in the study was the effect of the counselor's gender on a client's therapeutic involvement, self-concept and depression. They found no significant effect of counselor's gender. It appeared that time in treatment was more likely related to self-report of improvement rather than gender of the counselor. Whether time in treatment, the treatment itself, or a combination of both was responsible for a change in symptoms cannot be determined due to lack of a control group by which to compare results.

Another weakness in the Wagner et al.'s (1993) study was their lack of abuse-specific measures. Although depression scores did decrease, a few of the participants were not adjusting well after the six sessions. For example, the authors stated that one girl reported that she wanted to kill herself, and another five indicated that they thought about suicide but would not harm themselves. Such reports make one question what other post-treatment symptoms may have been present that were not identified in their measures. The author's used only self-report measures, which can be easily distorted by the participant. Incorporation of objective and abuse-specific measures may have identified other symptoms and dynamics that would have better explained the discrepancy between the decrease in depression scores and the girls' suicidal ideation. Multiple informants would also have been helpful in assessing behavior and would have strengthened the design and perhaps made the results more clinically applicable. As stated before, the absence of a comparison group poses a threat to internal validity and reduces the researcher's ability to rule out a maturation effect. This lack confounds the results with the possibility that symptom reduction may have been due to the passage of time rather than the treatment itself.

Lanktree and Briere (1995), recognizing the limitations of a quasi-experimental study and their threat to internal validity, attempted to control for the passage of time by incorporating this variable in their study. Multiple regression analyses were conducted on the data which suggested that although more time had passed between the average subject's last sexual abuse experience and the onset of his or her treatment, the time that subject spent in treatment was considerably more predictive of post-treatment symptomatology. Lanktree and Briere (1995) found that greater time in treatment was related to comparatively lower post-treatment distress on four of the Trauma Symptom Checklist (TSCC) scales (i.e., Anger, Depression, Dissociation, and Post-traumatic stress), as well as on CDI scores. Interestingly, what was also found was that greater passage of time from the last abuse experience to treatment was related to comparatively greater distress on the anger scale of the TSCC, as well as on the CDI. Lanktree and Briere (1995), like Friedrich and his colleagues (1992), compared the effects of total time from last abuse to the end of therapy to those of time in the therapy alone. The results of this analysis were in agreement with their first results. That is, time in treatment was negatively associated with Anger, Depression, Dissociation, and Post-traumatic Stress. On the other hand, total time from abuse to the end of treatment was positively related to Anger.

An interaction effect also appeared between the time since the participant's abuse and CDI scores, and the dissociation scale. Participants who had a relatively longer period of time lapse before getting into treatment and who stayed in treatment a relatively short period of time had significantly higher frequency of dissociations and higher CDI scores than did subjects with other combinations of time until treatment and time in

therapy (Lanktree & Briere, 1995). The evidence demonstrated a significant relation between time in treatment and the reduction of traumatic and depressive symptoms.

The reduction of symptoms was variable and different from subject to subject. Such variability in symptom reduction suggested that post-abuse symptomatology is not a unidimentional phenomenon as other studies have suggested. The most resistant symptom, according to Lanktree and Briere's (1995) study, was sexual preoccupation and/or sexualized behavior. Variables predicting treatment-related symptom reductions were few, but evidence did suggest that anxiety symptoms of subjects who were younger at the time of treatment were more responsive to therapy, and that those who pressed charges at the time of therapy demonstrated greater reduction of sexual concerns and dissociations.

Unique to this study was the use of repeated measures over a longer period of treatment. This allowed for the collection of more data concerning the relationship of treatment and symptoms over time. Also, the use of more specific sexual abuse measures such as the Trauma Symptom Checklist for Children allowed more specific measurement of abuse-related symptoms over time. The outcome data suggested that symptom reduction may require longer-term treatment for some children since Anxiety, Depression, and Post-traumatic Stress continued to decrease at time 4 (9 months) and 5 (12 months) on the TSCC scale. Weaknesses and limitations of the study included the lack of a comparison group, non-random assignment and reliance on self-report measures. As a result, its findings need to be supported by future studies, especially in the area of long-term treatment of sexual abuse symptoms.

Individual Long-term Treatment

Very few studies in the literature explore long-term treatment. In light of Lanktree and Briere's (1995) investigation, long-term treatment may be of benefit to some children to reduce symptoms associated with sexual abuse. Long-term treatment generally involves treatment that is longer than six months -- approximately one year to two years or longer.

Fenton (1993) affirmed a dissonance between the complexities of clinical experience and the limited scope of understanding provided by the current research. He provided a rich long-term narrative case study to address the patient's situation in clinically relevant terms. He documented and explored the dynamics in psychotherapy with a girl who had been sexually abused and had experienced unsuccessful efforts at outpatient and brief inpatient care. Strengths of the study included adherence to a specific mode of documented treatment (as defined by Levine & Wilson [1985]) that consisted of individual psychotherapy. Treatment initially took place in an inpatient setting and continued in an outpatient setting. During the treatment time, the subject was influenced by a number of adults in differing roles, as well as by peers in various capacities. Her exposure to these various other treatment experiences created numerous confounds to the study; thus, its conclusions of "improvement in functioning" based on treatment need to be interpreted with caution.

Chambless and Hollon (1998) stated that if a single case design is to be implemented, the study must have at least three subjects to meet one of the criteria for empirically validated treatments. Fenton's (1993) study does not meet any of these criteria. In addition, he did not use formal measures, and the data were anecdotal in

nature. With these recognized limitations, this study still offers worthwhile and clinically rich information. Single case studies have the advantage of collecting data from an intensive study of a few participants. Such intensive study provides an in-depth analysis of an individual's process that can be missed by most experimental designs.

Unique to this study was the longer-term follow-up of 20 months after the subject's discharge. Initially, the subject was described as quite severe in her clinical presentation. Before treatment, she had been in the hospital for nearly a year and had been responsible for more repeated incidents of assaults, absence without leaves (AWOLS), wrist cutting, and emergency room visits than any other patient in that hospital. Treatment lasted for two years and the follow-up was conducted 20 months after her discharge. At initial discharge, Fenton (1993) reported that she was able to find a part-time job in the community and no longer required acute hospital treatment. She was able to move to the supervised living program for adolescents while also attending school. Fenton further stated that she was seen as a reliable and valued employee and was able to develop relationships with her peer group at work. At follow-up, although the subject's functioning was not without problems, she reported no relapse into the inpatient or outpatient hospital and no use of medications. The subject continued to report "moderate" symptom severity including nightmares and restless and disturbed sleep. She reported that she remained employed about 75% of the follow-up time. Social relations were problematic, and very rarely would she meet with friends outside her "adoptive" family. She reported experiencing symptoms of moderate severity, including anxiety, depression, nightmares, and continued signs of posttraumatic stress syndrome about 75% of the follow-up period. Global functioning would be rated as moderate (Fenton, 1993)

This case study was clinically significant in that it showed the initial struggle the participant experienced with fear of closeness and intense inappropriate anger. Then, at follow-up, a capacity for self-reflection and a more objective look at interpersonal relations emerged. This capacity for self-observation allowed the participant to make better judgements about her behavior and work towards preserving her relationships with certain significant others.

Miller and Boe (1990) reported a case study with two girls, 8 and 10 years old. The two subjects were seen individually twice per week for sandplay over a period of 18 months. Miller and Boe (1990) observed an improvement in functioning for both subjects, but, again, no formal measures were utilized. Other weaknesses included ongoing treatments other than sandplay while the girls were on the unit at the hospital. With other ongoing treatments confounding the results, it is difficult to know how to attribute change.

Conclusions

The evidence in this review suggests that short-term treatment using both group and individual cognitive behavioral therapy demonstrated reduction of symptoms in children who have been sexually abused. However, studies of the long-term treatment were inconclusive. Many of these studies did not meet design criteria defined by Chambless and Hollon (1998) to be considered empirically validated treatments. Continued weaknesses in the literature include a low number of participants, lack of abuse specific measures, lack of long-term follow-up, lack of controlled studies, and, in some studies, the use of non-standardized instruments.

Review of the individual short-term treatment indicates that cognitive behavioral treatment was superior to unstructured and non-directive/non-supportive treatment in ameliorating symptoms associated with child sexual abuse. Finkelhor and Berliner (1995) stated in their review that those studies comparing the abuse-specific treatment to comparison or alternative treatment were inconsistent and that only Cohen and Mannarino's (1996) study suggested strong differences between cognitive behavioral therapy and non-directive/non-supportive treatment. Fairly consistent in the literature was an affirmation of the mediating effects of parental participation in treatment. Children who experienced parental support were more likely to experience a reduction in abuse related symptoms than were those who did not have parental support or were in an environment where chaos or division was prevalent.

Studies of long-term treatments were few in the literature. Those that were done had deficiencies in their design, casting doubt on the interpretation of the data as well as the generalizability of the results. The lack of long-term treatment studies is possibly reflective of the cost in performing such research. Given that studies such as Lanktree and Briere's (1995) demonstrated that some children might benefit from extended treatment, it would follow that future research is needed in this area to explore which symptoms are amenable to long-term treatment, what are the characteristics of the survivor that benefit and do not benefit from long-term treatment, does early intervention prevent or suppress symptoms in the future, and do the abuse-specific treatments alleviate symptoms long-term?

Well designed long-term treatment studies of sexually abused children are also needed to clarify the benefits of such treatment. Previous research appears to indicate that

abused children are at risk for long-term adverse psychological sequelae related to the abuse per se and not just as a consequence of other associated background factors (Stevenson, 1999). Investigating and planning for long-term treatment, then, appears to be necessary to meet the needs of these survivors of sexual abuse. Longer follow-up studies also need to be performed to further understand the benefits of short-term treatment and how it differs in its effect from that of long-term treatment. Finally, asymptomatic sexually abused children remain in need of further investigation because they may represent a unique percentage of this population in which symptoms may be muted or masked. Further study of asymptomatic children may shed light on questions of "sleeper effects," resiliency in children, and differences in the type of abuse on children's symptom profiles.

REFERENCES

Becker, J. V., Alpert, J. L., BigFoot, D. S., Bonner, B. L., Geddie, L. F., Henggeler, S. W., Kaufman, K. L., & Walker, C. E. (1995). Empirical research on child abuse treatment: Report by the child abuse and neglect treatment working group, American Psychological Association. Journal of Clinical Child Psychology, 24, 23-46.

Beitchman, J. H., Zucker, K. J., Hood, J. E., DaCosta, G. A., & Akman, D. (1991). A review of the short-term effects of child sexual abuse. Child Abuse & Neglect, 15, 537-556.

Benedek, E. P. (1985) Children and psychic trauma: A brief review of contemporary thinking. In S. Eth and R. S. Pynoos (Eds.), Post-traumatic stress disorder in children (pp. 3-16). Los Angeles, CA: American Psychiatric Association.

Berliner, L., & Wheeler, J. R. (1987) Treating the effects of sexual abuse on children. Journal of Interpersonal Violence, 2(4), 415-434.

Briere, J. (1992). Methodological issues in the study of sexual abuse effects. Journal of Consulting and Clinical Psychology, 60, 196-203.

Briere, J. (in press). Professional manual for the Trauma Symptom Checklist for Children (TSCC). Odessa, FL: Psychological Assessment Resources.

Celano, M., Hazzard, A., Webb, C., & McCall, C. (1996). Treatment of traumagenic beliefs among sexually abused girls and their mothers: An evaluation study. Journal of Abnormal Child Psychology, 24(1), 1-17.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. Journal of Consulting and Clinical Psychology, 66(1), 7-18.

Cohen, J. A. & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. Journal of the American Academy of Child and Adolescent Psychiatry, 35(1), 42-50.

Conte, J., & Berliner, L. (1987). The impact of sexual abuse on children: Empirical findings. In L. Walker (Ed.), Handbook of sexual abuse of children: Assessment and treatment issues. (pp. 72-93). New York: Springer.

Deblinger, E., McLeer, S. V., Henry, D. (1990). Cognitive behavioral treatment for sexually abused children suffering post-traumatic stress: Preliminary findings. Journal of the American Academy of Child and Adolescent Psychiatry, 29(5), 747-752.

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering post-traumatic stress symptoms: Initial treatment outcome findings. Child Maltreatment, 1, 310-321.

Downing, J., Jenkins, S. J., & Fisher, G. L. (1988). A comparison of psychodynamic and reinforcement treatment with sexually abused children. Special Issue: Child abuse. Elementary School Guidance & Counseling, 22(4), 291-298.

Farrell, S. P., Hains, A. A., & Davies, H. W. (1998). Cognitive behavioral interventions for sexually abused children exhibiting PTSD symptomatology. Behavior Therapy, 29, 241-255.

Fenton, W. S. (1993). Sexual abuse and psychopathology. Psychiatry, 56, 205-227.

Finkelhor, D. (1987). The trauma of child sexual abuse. Journal of Interpersonal Violence, 2(4), 348-366.

Finkelhor, D. (1994). Current information on the scope and nature of child sexual abuse. The Future of Children, 4(2), 31-53.

Finkelhor, D., & Berliner, L. (1995). Research on the treatment of sexually abused children: A review and recommendations. Journal of the American Academy of Child and Adolescent Psychiatry, 34(11), 1408-1423.

Finkelhor, D., & Brown, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. American Journal of Orthopsychiatry, 55(4), 530-541.

Friedrich, W. N., Grambasch, P., & Damon, L. (1992). Child Sexual Behavior Inventory: Normative and clinical comparisons. Psychological Assessment, 4, 303-311.

Furniss, T., Bingley-Miller, L., & Van Elburg, A. (1988). Goal-oriented group treatment for sexually abused adolescent girls. British Journal of Psychiatry, 152, 97-106.

Glaser, D. (1991). Treatment issues in child sexual abuse. British Journal of Psychiatry, 159, 769-782.

Grayston, A. D., & DeLuca, R. V. (1995). Group therapy for boys who have experienced sexual abuse: Is it the treatment of choice? Journal of Child & Adolescent Group Therapy, 5, 57-82.

Hack, T. F., Osachuk, T. A. G., & De Luca, R. V. (1994). Group treatment for sexually abused preadolescent boys. Families in Society, 75(4), 217-228.

Hall-Marley, S. E., & Damon, L. (1993). Impact of structured group therapy on young victims of sexual abuse. Journal of Child and Adolescent Group Therapy, 3(1), 43-48

Hiebert-Murphy, D., De Luca, R. V., & Runtz, M. (1992). Group treatment for sexually abused girls: Evaluating outcome. Families in Society, 73(4), 205-213.

Hyde, C., Bentovim, A., & Monck, E. (1995). Some clinical and methodological implications of a treatment outcome study of sexually abused children. Child Abuse and Neglect, 19(11), 1387-1399.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and sythesis of recent empirical studies. Psychological Bulletin, 113, 164-180.

Kitchur, M., & Bell, R. (1989). Group psychotherapy with preadolescent sexual abuse victims: Literature review and description of an inner-city group. International Journal of Group Psychotherapy, 39(3), 285-310.

Kolko, D. J. (1986). Social-cognitive skills training with a sexually abused and abusive child psychiatric inpatient: Training generalization, and follow-up. Journal of Family Violence, 1, 149-165.

Lanktree, C. B., & Briere, J. (1995). Outcome of therapy for sexually abused children: A repeated measures study. Child Abuse and Neglect, 19(9), 1145-1155.

Mannarino, A. P., Cohen, J. A., Smith, J. A., & Moore-Motily, S. (1991). Six and twelve month follow-up of sexually abused girls. Journal of Interpersonal Violence, 6, 494-511.

Mannarino, A. P., Cohen, J. A., & Berman, S. R. (1994). The Children's Attributions and Perceptions Scale: A new measure of sexual abuse-related factors. Journal of Clinical Child Psychology, 23, 204-211.

Marsh, H. W. (1986). Negative item bias in rating scales for preadolescent children: A cognitive-developmental phenomenon. Developmental Psychology, 22, 37-49.

McGain, B., & McKinzey, R. K. (1995). The efficacy of group treatment in sexually abused girls. Child Abuse and Neglect, 9, 1157-1169.

McLeer, S. V., Deblinger, E., Atkins, M. S., Foa, E. B., & Ralphe, D. L. (1988). Post-traumatic stress disorder in socially abused children. Journal of the American Academy of Child and Adolescent Psychiatry, 27, 650-654.

Miller, C., & Boe, J. (1990). Tears into diamonds: Transformation of child psychic trauma through sandplay and storytelling. Arts in Psychotherapy, 17(3), 247-257.

Nelki, J. S., & Watters, J. (1989). A group for sexually abused young children: Unraveling the web. Child Abuse and Neglect, 13, 369-377.

O'Donohue, W. T., & Elliott, A. N. (1992). Treatment of the sexually abused child: A review. Journal of Clinical Child Psychology, 21(3), 218-228.

Pilkonis, P. A. (1993). Studying the effects of treatment in victims of childhood sexual abuse. Journal of Interpersonal Violence, 8, 392-401.

Sinclair, J. J., Larzelere, R. E., Paine, M., & Jones, P. (1995). Outcome of group treatment for sexually abused adolescent females living in a group home setting: Preliminary findings. Journal of Interpersonal Violence, 10, 533-542.

Spaccarelli, S. (in press). Measuring abuse stress and negative cognitive appraisals in child sexual abuse: Validity data on two new scales. Journal of Abnormal Psychology.

Stevenson, J. (1999). The treatment of the long-term sequelae of child abuse. Journal of Child Psychology and Psychiatry, 40(1), 89-111.

Wagner, W. G., Kilcrease-Fleming, D., Fowler, W. E., & Kazelskis, R. (1993). Brief-term counseling with sexually abused girls: The impact of sex of counselor on clients' therapeutic involvement, self-concept, and depression. Journal of Counseling Psychology, 40(4), 490-500.

Wolf, V. V., Gentile, C., & Wolf, D. A. (1989). The impact of sexual abuse on children: A PTSD formulation. Behavioral Therapy, 20, 215-228.